

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER

445148

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

B. WING

(X3) DATE SURVEY  
COMPLETED

04/19/2010

NAME OF PROVIDER OR SUPPLIER

DONELSON PLACE CARE &amp; REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

2733 MCCAMPBELL ROAD  
NASHVILLE, TN 37214(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)ID  
PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)(X5)  
COMPLETION  
DATEK 025  
SS=D

## NFPA 101 LIFE SAFETY CODE STANDARD

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined, the facility failed to maintain the fire barriers as required. National Fire Protection Association 101, 8.3; 19.3.7.3;

The findings included:

On 4/19/10 at approximately 11:06 AM observation within the dietary area revealed a 1/2" diameter penetration in the one hour smoke/fire wall.

The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/19/10.

K 029  
SS=E

## NFPA 101 LIFE SAFETY CODE STANDARD

One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system

K 025

NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

## REQUIREMENT:

The facility will ensure that smoke barriers are maintained in accordance with NFPA 101, 8.3; 19.3.7.3.

## CORRECTIVE ACTION:

1. The penetration of the smoke barrier in the dietary area was sealed on 4-19-10.
2. The maintenance director inspected all smoke and fire barriers for unsealed penetrations on 4-20-10 with no additional findings.
3. The maintenance director will conduct routine audits of smoke and fire barriers to ensure proper sealing of any penetrations.
4. The maintenance director will monitor for compliance through routine audits of the facility. These audits will be logged on the QA inspection log and reviewed in quarterly QA meetings.

COMPLETION DATE: 04-23-10

K 029

NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

## REQUIREMENT:

The facility will ensure that smoke barriers are maintained in accordance with NFPA 101, 8.3; 19.3.7.3.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

5-7-10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029

Continued From page 1

option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined, the facility failed to maintain the fire barriers as required. National Fire Protection Association 101, 8.3.6.1; 19.3.2.1.

The findings included:

On 4/19/10 at approximately 11:30 AM observation within the boiler room revealed an open conduit in the floor without any fire caulk seal or metallic cap.

The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/19/10. NFPA 101 LIFE SAFETY CODE STANDARD

K 061  
SS=E

Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1

This STANDARD is not met as evidenced by: Based on observation, it was determined, the

K 029

**CORRECTIVE ACTION:**

1. The open conduit in the boiler room was sealed on 4-20-10.
  2. The maintenance director inspected all smoke and fire barriers for unsealed penetrations on 4-20-10 with no additional findings.
  3. The maintenance director will conduct routine audits of smoke and fire barriers to ensure proper sealing of any penetrations.
  4. The maintenance director will monitor for compliance through routine audits of the facility. These audits will be logged on the QA inspection log and reviewed in quarterly QA meetings.
- COMPLETION DATE:** 04-23-10

K 061

**NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E****REQUIREMENT:**

The facility will ensure that the sprinkler system Post Indicator Valve is locked in accordance with NFPA 13, 2.7.1.1; 72: 9.7.2.1

**CORRECTIVE ACTION:**

1. The maintenance director secured the sprinkler system's Post Indicator Valve on 4-19-10.
2. The maintenance supervisor inspected the sprinkler system for proper maintenance on 4-20-10 with no additional findings.

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K 061	Continued From page 2 facility failed to maintain and supervise the sprinkler valves as required.  The findings included:  On 4/19/10 at 11:20 AM observation revealed, the sprinkler Post Indicator 'overhead' Valve was not locked, even though the 'flow' valve was open. NFPA 13, 2.7.1.1; 72; 101, 9.7.2.1.  The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/19/10.	K 061	3. The maintenance director will conduct routine inspections of the sprinkler system to ensure proper function and maintenance. 4. The maintenance director will monitor for compliance through routine audits of the facility. These audits will be logged on the QA inspection log and reviewed in quarterly QA meetings.  COMPLETION DATE: 04-23-10	
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation during the survey, it was determined, the facility failed to maintain the portable fire extinguishers as required.  The findings included:  On 4/19/10 at 11:52 AM observation revealed, most of the portable fire extinguishers in the main halls 200 and 100 were mounted above the 5' maximum height. National Fire Protection Association (NFPA) 10, 1.6.10.  The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/19/10.	K 064	NFPA 101 LIFE SAFETY CODE STANDARD SS=E  REQUIREMENT: The facility will ensure that portable fire extinguishers are mounted at the proper height in accordance with NFPA 10, 1.6.10  CORRECTIVE ACTION: 1. The maintenance team adjusted the height on the fire extinguishers as necessary throughout the facility on 4-23-10. 2. The maintenance supervisor audited all fire extinguishers for proper height on 4-23-10. 3. The maintenance director will monitor fire extinguishers for proper maintenance during monthly audits and will correct any findings immediately. 4. The maintenance director will monitor for compliance through routine audits of the facility. These audits will be logged on the QA inspection log and reviewed in quarterly QA meetings.  COMPLETION DATE: 04-23-10	

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DATEK 130 NFPA 101 MISCELLANEOUS  
SS=C

OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:  
Based on observation during the survey, it was  
determined, the facility failed to maintain  
flammable liquids in storage areas as required.  
NFPA 99; 55, 6.6.

The findings included:

On 4/19/10 at 11:35 AM observation within the  
boiler room revealed an unsecured helium tank in  
storage.

The deficiency was verified by the Maintenance  
Director and later acknowledged by the  
Administrator during the exit interview on 4/19/10.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

Generators are inspected weekly and exercised  
under load for 30 minutes per month in  
accordance with NFPA 99. 3.4.4.1.

This STANDARD is not met as evidenced by:  
Based on observation during the survey, it was  
determined, the facility failed to maintain the  
emergency generator as required.

K 130 NFPA 101 MISCELLANEOUS  
SS=C

## REQUIREMENT:

The facility will ensure that flammable liquids are  
stored in accordance with NFPA 99; 55, 6.6.

## CORRECTIVE ACTION:

1. The maintenance director secured empty helium tank on 4-19-10.
2. The maintenance team audited the facility to ensure that all flammable material was properly stored on 4-20-10 with no additional findings.
3. The maintenance director will perform monthly audits for proper storage of flammable materials and correct any findings immediately.
4. The maintenance director will monitor for compliance through routine monthly audits of the facility. These audits will be logged on the QA inspection log and reviewed in quarterly QA meetings.

COMPLETION DATE: 04-23-10

K 144 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

## REQUIREMENT:

The facility will ensure that the generator is  
properly maintained in accordance with NFPA 99,  
3.4.4.1

## CORRECTIVE ACTION:

1. The generator maintenance company repaired the generator on 4-19-10.
2. The maintenance director will monitor the emergency generator system for proper operation on a weekly basis.
3. The maintenance director will conduct full system audits of the generator system on weekly and monthly basis and any findings will be addressed immediately.

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The findings included:

On 4/19/10 at 11:45 AM observation revealed, the emergency generator did not start on test. National Fire Protection Association (NFPA) 110, 6-4.2. The deficiency was corrected by the Maintenance service company prior to the end of the survey.

The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/19/10.

K 144

4. The maintenance director will monitor for compliance through routine audits of the generator system. These audits will be logged on the QA inspection log and reviewed in quarterly QA meetings.

COMPLETION DATE: 04-23-10